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BODY IMAGE AND FUNCTIONAL LOSS IN STROKE EXPERIENCE OF PSYCHOLOGICAL CARE THROUGH EFT: A CASE STUDY

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Abstract: Cerebrovascular accidents (CVAs) are the leading cause of death along with cardiac events. They represent the third cause of mortality and the first cause of acquired disability in Western countries. Strokes increase with age: 78% of strokes occur after age 75. If two thirds of elderly people survive a stroke, half have serious after-effects which open the door to other types of disorders which render doctors powerless in an environment which is conspicuous by the absence of psychological support.

This article aims to evaluate psychological disorders after a major stroke and provide psychological care using EFT therapy. We set up an experimental study during which we evaluated psychological disorders (body image, anxiety, depression), in a sample composed of 15 participants, at different times after a major stroke. : during the initial hospitalization, after returning home, six months and nine months after the accident. At the same time, we also administered psychological care during the nine months of the study.

The initial assessment (T1) shows body dissatisfaction and progressive integration of the new body and a significant reduction in anxiety-depressive type mood disorders after the start of EFT therapy. These results underline the need not to neglect the importance of psychological management, from the acute phase, of somatic symptoms, independently of the prognosis of neurophysiological recovery. On the other hand, our results highlight a reduction in the severity of psychological symptoms and an acceptance of the new body among the participants.

Key words: Stroke, Aftereffects, EFT, Body image

Introduction

Cerebrovascular accidents (CVAs) are the leading cause of death along with cardiac events. They represent the third cause of mortality and the first cause of acquired disability in Western countries. Strokes increase with age: 78% of strokes occur after age 75. Although two thirds of elderly people survive a stroke, half have serious after-effects. Mortality is 20% at 1 month, the risk of recurrence is 30% at 5 years. These are ischemic cerebral accidents (interruptions of blood flow in the cerebral arteries causing softening of the tissues) in 80% of them or hemorrhagic accidents (rupture linked to a malformation of the vessel called aneurysm) in 20%. cases or following direct damage to the carotid or vertebral artery following shock, arterial malformations or abnormalities in blood coagulation properties (Frénisy et al., 2005; Calmels et al. 2005). The symptoms vary depending on the arterial territory concerned.

There are multiple risk factors: high blood pressure, diabetes, cholesterol, tobacco, etc.

Strokes are a medical emergency, where diagnostic and therapeutic care must be carried out jointly. Optimization of treatment and improvement of the prognosis depend on the precocity of the positive and etiological diagnosis.

The disability and psychological after-effects generated by the stroke create a new pathological state for which the doctor is powerless and the absence of multidisciplinary care disrupts the management of the stroke and exposes it to complications of a psychopathological nature.

The problem that this article seeks to resolve is the acceptance of acquired post-stroke disability and the articles have a dual objective, namely the evaluation of post-stroke psychological disorders and the administration of psychological care through EFT therapy in a patient.

1. Presentation of the psychopathological problem

Disability represents an attack on the body and/or psyche of the individual; he comes to question the body of the subject, and what this body represents for him. The body inscribes as much as it bears witness to a reality. The physical and/or psychological disability affects the representation that the subject may have of himself and finds an echo within his psychological dynamics. This context supposes that alterations of the real or biological body find an echo on the psychological scene, which is evidenced by psychopathology.

In this specific case, the psychologist considers, in addition to clinical reality, its place in the period of life considered. The stroke thus occurs in a temporality specific to the subject and the inscription in his history confronts him with a logic of the event that can cause trauma. The place of the somatic is thus in the foreground and the image of the altered body reveals psychological issues to be taken into account. Depression and anxiety demonstrate the importance of considering the psychological impact of the stroke but also the extent of the disability and its psychopathological consequences.

1.1. Body image

Bob Price, presents body image content that integrates all dimensions and shows the difficulties posed by changing appearance.

Body image consists of the actual body, the ideal body, and the appearance body. The first undergoes transformations due to aging but also to illness. It is the body entrusted to the healthcare team to be repaired (Consoli, 2008). The ideal body is the mental representation referring to the standards of society which today correspond to a thin and toned body, as illustrated by women's magazines which devote most of their articles to beauty, thinness or other aspects affecting this area. The last represents our manners, our way of dressing, that is to say what we seek to show (Price, 1998). Body image impairment is defined when “there is a marked difference between the current perceived appearance or functioning of a given body attribute and the individual’s ideal perception of that attribute; this difference, by virtue of personal investment and bodily dysfunctions, has emotional and behavioral consequences, and can significantly affect the quality of occupational, social and relational functioning. » (White, 2000). Stroke and its treatments therefore affect the individual's real body, causing a significant gap between their perceived body representation and their ideal perception, leading to a real alteration of their body image.

The exact nature of body image disturbances in stroke is certain because stroke is the leading cause of adult disability worldwide (Skrzypek et al., 2001; Farell & Shafran, 2005).

1.2. Depression

Post-stroke depression is the affective disorder most commonly associated with stroke. It affects 30 to 50% of hemiplegic patients in the two years following the stroke, with major physical and social repercussions. Studies on post-stroke depressive symptoms in elderly subjects report a prevalence ranging from 11 to 50% and mainly at the beginning of the rehabilitation phase, in 8 to 67% of cases. The large variability in the frequency of post-stroke depression between studies can be explained mainly by the diversity of methods used to objectify depression, with some studies using the search for depressive symptoms and others using stricter DSM criteria. like those of major depression (Pariel-Madjlessi et al., 2005). Furthermore, the DSM-IV diagnostic criteria for depression after a stroke (depression linked to an organic illness) can be superimposed on the criteria for so-called endogenous or functional depression (without brain damage).

Stroke patients with post-stroke depression are characterized by severe alterations in attentional abilities, greater mood fluctuations, greater psychomotor slowing (decreased autonomy), more marked anxiety and more somatic and vegetative symptoms (Carota, 2005). They experience a traumatic event which undermines their bodily and mental integrity, their autonomy and their personal esteem as well as their family, social and professional life by disrupting their habits and quality of life.

1.3. Anxiety

The first reaction generally experienced by individuals after a stroke is anxiety, a natural reaction in response to danger. According to studies, a quarter of patients have a high degree of anxiety immediately after a stroke. This anxiety tends to persist for the following year. It should be noted that patients who have already experienced cardiac problems show more signs of anxiety than others immediately after a stroke (Boersma, Joekes, 2005). We also note higher levels of anxiety after a cardiac accident for patients in great emotional distress at the time of the stroke (Whitehead, strike, Perkins-Porras & steptoe, 2005).

In order to protect their heart and reduce their anxiety, patients tend to reduce their social life and physical activity. The paradox is that by reducing them, they become deconditioned, become more tired and become more easily overwhelmed by their symptoms. This ultimately results in increased anxiety (Thompson & Lewin, 2000).

1.4. Choix du cas

Mr. BM is a 48-year-old accountant, married and father of two grown children, known and monitored for hypertension, a retrenchment in his company greatly disrupted his calm and plunged him into a serious black streak. After an ischemic stroke with sequelae: upper limb impotence and spasticity. He received a lot of attention from his family and his colleagues but for him, his body imposes itself in the relationship with the homeless subject in several aspects. For him, his new body is a source of suffering and no longer recognizes the house in which he lives. His body is a place of important psychological issues both in its abandonment by the subject who no longer feels pain, and in the staging of the body and the suffering that emerges there.

1.5. Patient request

He wants us to explain to him what happened, why from one day to the next he found himself “paralyzed on the left side”. He feels like he has lost control of his existence. He is very worried and depressed.

1.6. Interest of the case

The case presented offers an example of a complex situation, that of an elderly patient (48 years old) with a medical history (hypertension, frequent headaches for example) and without psychiatric history, victim of a stroke with functional loss.

In cases like that of Mr. BM, offering a diagnostic examination in a specialized hospital center has several advantages. It is possible to meet the patient for a sufficient time to carry out a psychological assessment. This assessment gives a good indication of the psychological capacities or limits of a patient to elaborate their psychological conflicts, to be able or not to cope with them. The analysis and interpretation of the assessment will allow us to better understand what characterizes the patient's medical and psychopathological problems. This information is extremely important for setting up therapeutic monitoring.

2. Methodology

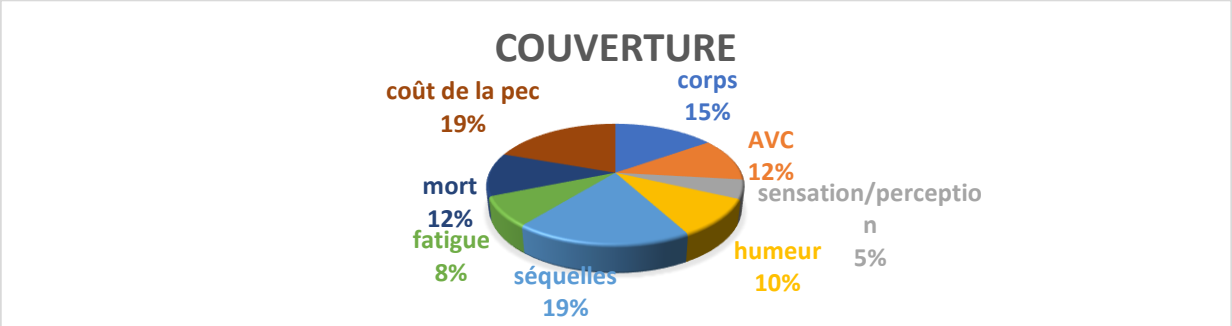
The study has two large parts, a first evaluating psychological disorders using the STAI Y-A, Y_B, the BDI, and the QIC and a second part which is carried out by the intervention of EFT therapy over nine months with evaluations to highlight the impact of EFT therapy. To evaluate the effects of EFT therapy, an evaluation is done every three months to assess the patient's psychological dynamics.

3. Results

3.1. Scale results

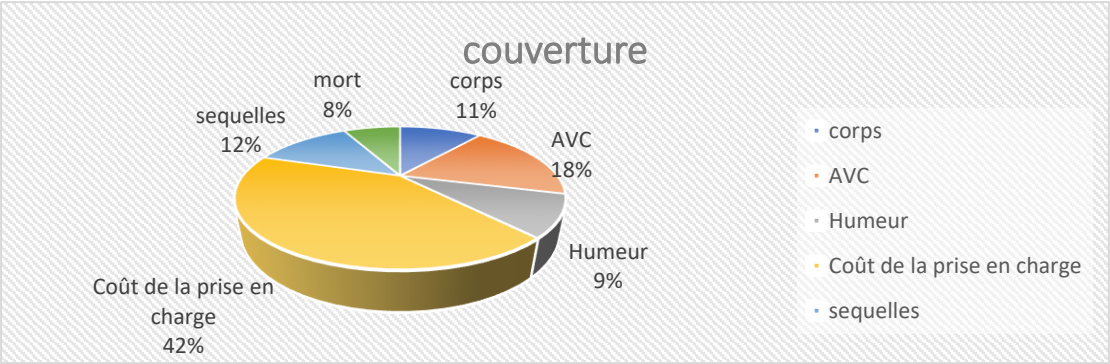
To make the results easier to read, they are combined in three tables, each table representing a time and separated from the next by three of EFT therapy.

Temps 1				
Test	**STAI Y – B**	**BIQ**	**BECK**	**STAI Y - A**
Score	Élevé	Insatisfait	Dépression sévère	Très élevé



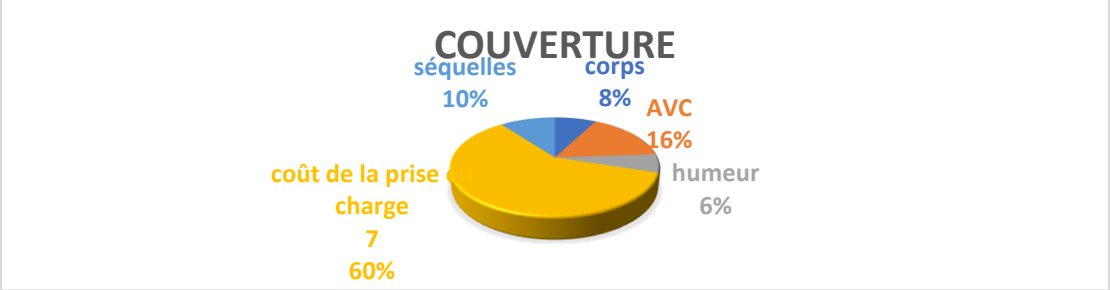
The functional alteration has caused a break in the subject's life and the psychological resources affected by the illness do not allow it to be developed. In order to consider an orientation for his exit (home). The assessment of his psychological state linked to his current problem highlights the diagnosis of body image disorder against a background of anxio-depressive type mood disorder.

Temps 2				
Test	**STAI Y – B**	**BIQ**	**BECK**	**STAI Y - A**
Score	Moyen	Insatisfait	Dépression moyenne	Faible

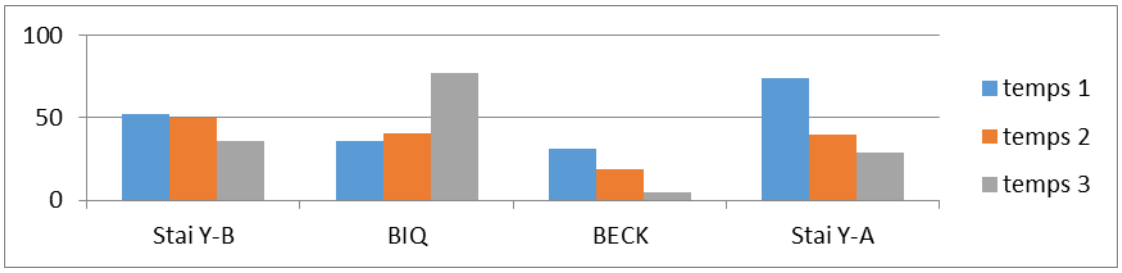


At time 2 the results show a regression in the severity of all the modalities, namely, at Time 1 the depression which was severe goes to average, the anxiety in these two scales goes from high to average for the STAI-B and from very high to low and for the ICQ we go from severe dissatisfied to dissatisfied for the first three months of EFT therapy administration

Temps 3				
Test	**STAI Y – B**	**BIQ**	**BECK**	**STAI Y - A**
Score	Faible	Satisfait	Pas de dépression	Très faible



Summary



Examination of the metric data recorded in the tables above for the case are generally satisfactory. The results of the average STAI Y – B at time 1 are low at times 2 and 3. For the evolution of body image, it is good to note that the initial situation at time 1 which was unsatisfactory improves considerably in a satisfactory assessment at times 2 and 3. The results on depression have evolved in a positive manner. The high level of depression recorded at baseline (time 1) completely disappeared at time 3. As for the evolution of anxiety, at time 1 it was recorded that it was high at time 1 and then it decreased to become low at times 2 and 3.

For the person suffering from a sequelae stroke, now a person with a disability, the body occupies the center stage for much longer, an object of care (physical and psychological dependence) and attention as well as a brake on edification. of the private connection to oneself and to the outside world. Through the tools, we noted the presence of suffering through the modalities of: depression, anxiety and body dissatisfaction after a stroke with after-effects but, also the tools highlighted the role of care psychological that is EFT in this study by significantly reducing the severity of suffering over the course of the study between times 1 and times 3.

Discussion

The experience of stroke as reported here is similar to that of other works in that the experience of post-stroke life is dominated by suffering, dependence and change in social role. Suffering, that of no longer 'being the same as before', often plays an important role because of the dependence it creates between the survivor and those around them (Pilkington, 1999). It also arises in the post-stroke experience, because the illness marks a break between life before and after the illness. This is a common biographical break in the experience of chronic illness (Bury, 1991).

Improving body image through EFT has shown promising results in improving body image in breast cancer patients after mastectomy and chemotherapy. One study found a significant decrease in negative body image scores after EFT intervention (Anggreini & Sari, 2021). Treatment of Body Dysmorphia: Controlled trials have demonstrated that cognitive behavioral therapy, including EFT, significantly reduces symptoms of body dysmorphia, with sustained long-term improvements (Rosen et al., 1995). Mood Reduction and Improved Mental Health: EFT has been effective in reducing symptoms of anxiety, and depression, which may indirectly improve body image by reducing associated negative emotions (Rogers & Sears, 2015).

The EFT protocol promotes observable behavioral change in bodily engagement and manifested pleasure. It is a true place of freedom that allows participants to express themselves, get moving and have fun. Smiles, memories, jokes are present during the sessions. Pleasure is a real motivation for participants which pushes them to become more involved in the practice of therapy. These results are consistent with other studies and action plans which have highlighted the existing links between EFT and the notion of pleasure (Kino-Québec, 2000). In addition, our results are supported by those of Herbinet (2002) who show the benefits of the EFT protocol during the hospitalization period. This study emphasizes the importance of follow-up upon discharge from hospital which is not always easy to put in place and which is not sustainable afterwards.

Conclusion

The occurrence of a stroke is a major event that causes upheaval in the daily life of the patient and those around them. In fact, more than half of the victims present motor, cognitive and/or behavioral after-effects causing a disability. They strongly impact their quality of life and their autonomy in carrying out daily activities within the home, in external travel as well as in their social relationships. Furthermore, the drug treatment established to prevent recurrences must be maintained for life. It requires good compliance with precautions for use and health and diet rules to be respected, and can be perceived as a real constraint.

Thanks to his skills and proximity, the psychologist can integrate and facilitate this post-stroke care. Beyond its role in providing psychological care, it actively participates in therapeutic education, particularly through the implementation of clinical interviews, psychoeducation and EFT psychotherapy. Likewise, the relationship of trust that he establishes with patients allows him to know their feelings and to help them improve their daily lives by directing them towards suitable professionals or by offering them home improvement solutions. However, the role of the psychologist in post-stroke care is still largely underestimated today. Although its missions tend to develop over time, its integration within the multidisciplinary team remains too discreet and only needs to be strengthened.

Bibliography

1. American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.).
2. A. Schnitzler, 2015. « Handicap dans les suites d'un accident vasculaire cérébral : étude de prévalence et impact des filières de soins » (thèse de doctorat). Université de Versailles Saint-Quentin-en-Yvelines, Ecole doctorale des Génomes Aux Organismes, 184p.
3. Calmels, Paul & Béthoux, François & Roche, G. & Fayolle-Minon, Isabellei & Picano-Gonard, C.. (2003). Évaluation du handicap et de la qualité de vie chez les blessés médullaires : étude d'un échantillon de population de 58 sujets vivant à domicile. Annales de Réadaptation et de Médecine Physique. 46. 10.1016/S0168-6054(03)00084-9.
4. Farrell, Clare & Lee, Michelle & Shafran, Roz. (2005). Assessment of body size estimation: A review. European Eating Disorders Review. 13. 75 - 88. 10.1002/erv.622.
5. Frénisy M.C., Minot D., Soutenet M., Amiot N. (2005), « Accidents vasculaires cérébraux : approche psychopathologique et approche neuropsychologique. A propos d'un cas : MJ », *Annales Médico-Psychologiques*, 136, 65-72.
6. LE Breton D., La sociologie du corps, Paris, P.U.F, Que sais-je ?, 1992.
7. Schilder P., L'image du corps. Paris, Gallimard, 1968.